post transfusion, transfusion care, observations chart and record of care.

**Demographics** Only 62% of health professionals are wrote the patient details on every sheet while there and there were 15% who are not following the correct guidelines for patient identification especially for correct labelling of the blood samples.

**Blood prescription sheet** 85% did not write the target hemoglobin however some aspects are being followed by the prescribers.

**Pre-transfusion** 77% did not state the diagnosis and only 43% are documenting the venous access site.

All sections in the transfusion care and post transfusion care were not completed appropriately. Only 51% of the nurses, record observations 15 minutes after the start of the transfusion.

**Conclusion** Following the use of blood transfusion proforma is thought to be one of the key documents to support the prevention of blood transfusion error. This enabled the pediatric department to achieve the NICE standard of care for blood transfusion. There are still a lot of work that must be done to say that we will be able to safeguard our patients from mistakes. The results of the audit only show a moderate adherence to the national guideline. There is a need to implement an action plan to improve the practice and some of which are: all staff involved in giving blood transfusion should be required to attend blood transfusion updates every year; reiterate the importance of accurate recording of observations; the implementation of patient identification guidelines should be strictly followed and the proforma needs to be audited every six months.

**a1184**

**PATIENT TRANSFER PROCESS: ARE WE LEARNING FROM THEM? – A QUALITY IMPROVEMENT PROJECT**

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**Aims** Transfers are common practice from District General Hospitals (DGHs). The reasons for transfers are multiple ranging from need for intensive care, surgical care, new oncological diagnosis and sometimes lack of bed capacity.

Transfers present an opportunity for learning around clinical management, teamwork, communication, and improvement in patient care.

In our DGH, meetings to discuss transfers were infrequent and as such learning sometimes remain at an individual level and is not always a shared event.

The team thus set out to capture all the transfers done in the year 2021 at our DGH, to understand practice around documentation, follow-up and learning after transfers and as such improve service provision and promote shared learning.

**Methods** It was part retrospective and part prospective, and data was captured from transfer book and compared with the central database. The data was then analysed on excel.

**Transfers were analysed for**

* Hospital transferred to
* Reason for transfer
* Receipt of feedback from the receiving hospitals

* Follow-up post transfer at local hospital
* Availability of discharge letter post transfer

We also compared the data in the transfer book with the central data base. The central database showed the total inpatient transfers as 97 however the total number of transfers from the Emergency Department (ED) remain uncertain. We went on to analyse the 71 transfers recorded in the book of which 21 were from ED.

**Results** From available numbers only 60% of transfers were currently being captured (71 out of 118). However, it is likely this percentage is even less.

Of the 71 transfers, 67.6% of the transfers were to the Birmingham Children’s hospital, 10% to Royal Stoke Hospital and the rest to surrounding DGHs.

The 3 highest reasons for transfer were surgical intervention (24%), need for intensive care (21%) as well as lack of bed capacity (10%)

In terms of receiving feedback and summary from receiving hospitals following transfers, in 67.6% of the cases there was no feedback and in only 32.4% was there a formal letter done summarising care after the transfer (figure 1).

In terms of follow-up post transfer, the survey showed that 45% had no local follow up and the rest 55% had a local follow-up which had either been arranged or attended (figure 2).

The survey showed, 65% of the transfers had a Paediatric discharge letter, 29% had an Emergency department discharge letter and 4% (6) had no discharge letters post transfers.

**Abstract 1184 Figure 1 Feedback after transfer**

**Abstract 1184 Figure 2 Follow up at new cross hospital**
Conclusion Only 60% of the total transfer were recorded in the transfer book. 67.6% of patients in our DGH had no feedback letter summarising care given at the receiving hospital and 45% of patients had no local follow-up post transfer. All of which have impact on continuity of care at our local DGH. Following on from this survey, clear pathways are underway to ensure all patients transferred are captured in the book as well as an automatic system of follow-up post transfer and a system of regular review of transfers to share learning and continually improve patient care.

SERVICE EVALUATION PROJECT IN A BUSY DGH TO ASSESS READMISSION OF NEONATES TO CHILDREN’S ASSESSMENT UNIT WITH JAUNDICE AND WEIGHT LOSS WITHIN 48 HOURS OF DISCHARGE

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Aims Neonatal jaundice and weight loss are one of the commonest reasons of readmission to the Children’s assessment unit and make up bulk of hospital admissions almost every day of the week irrespective of the time of the year. The main aim of this service evaluation project was to investigate the reasons for these immense readmissions to the paediatrics unit but also to try creating new pathways or protocols that would not only help not only reduce patient load on clinicians but, also reduce the added stress on exhausted mothers who suffer the guilt of ‘failing their new born babies’.

Methods To achieve our objectives, a retrospective study of all neonatal admissions to Children’s assessment unit between the months of April to December 2020 was conducted using a questionnaire drafted for this purpose. Our selection criteria included only those babies who were readmitted within 48 hours of discharge home since birth. All other causes for readmission were excluded. Our sources for data collection were from widely used software within neonatal units across the country called ‘Badgernet’ and local trust records of neonatal and paediatric handover sheets from 2020.

Results 60 patient notes from April to December 2020 were reviewed of which only 42 met our selection criteria, and hence the remaining 18 were excluded from the project. All 42 babies 37 were admitted from either the postnatal ward 3 from SCBU and 2 from transitional care.

26 of 42 neonates were seen within 48 hours of discharge from hospital which made up 62% of all readmissions, of which 3.7% were within 24 hours. The remaining 38% were admitted between 72 hours and 96 hours which were beyond the realm of this project (figure 1). The commonest reason for readmission was observed to be jaundice in 11 out of 26 neonates making up almost half of the readmissions. The other causes were weight loss seen in 9 out of 26 babies followed by combined jaundice and weight loss in 6 of 26 neonates (figure 2).

Conclusion From the data collected it was evident that these large number of readmissions occurred throughout the year, with exhausted parents spending hours waiting to be reviewed only to be informed of readmission.

The solution is far from simple, yet achievable by developing direct referral pathways to postnatal wards bypassing the hectic children’s assessment unit and by creating a proforma...